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ABSTRACT

This booklet describes characteristics of hyperactive children and discusses identification procedures, causes, treatment, and future developments in this area. Actual diagnosis of hyperkinetic behavior syndrome, commonly referred to as hyperactivity, is complex and should include a thorough examination by a pediatrician, and sometimes a child psychologist, psychiatrist, or a neurologist. The exact cause of hyperactivity is unknown; no single cause has been established. Medication, diet, and psychological interventions have been used with varied success to treat hyperactive children. Parents and other adults involved with hyperactive children should help them experience success in educational and social situations to help them improve their self-image and increase their motivation to behave appropriately. It is important that intervention begin as soon as possible to keep such potential outcomes as underachievement and negative self-esteem from becoming long-term problems. (JW)

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caring about KIDS

helping the hyperactive child

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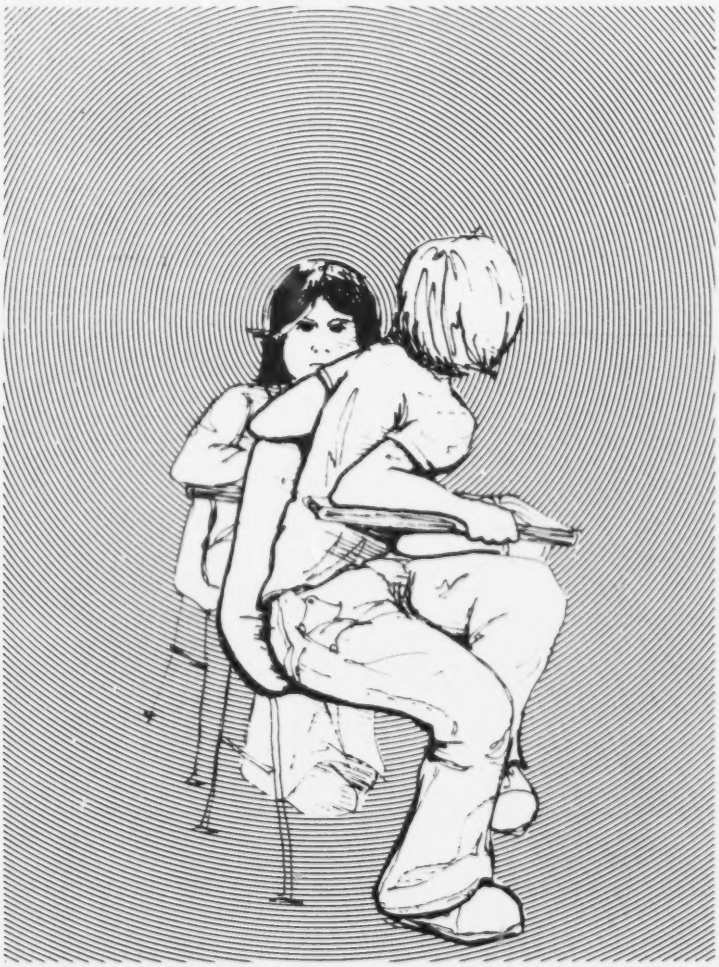
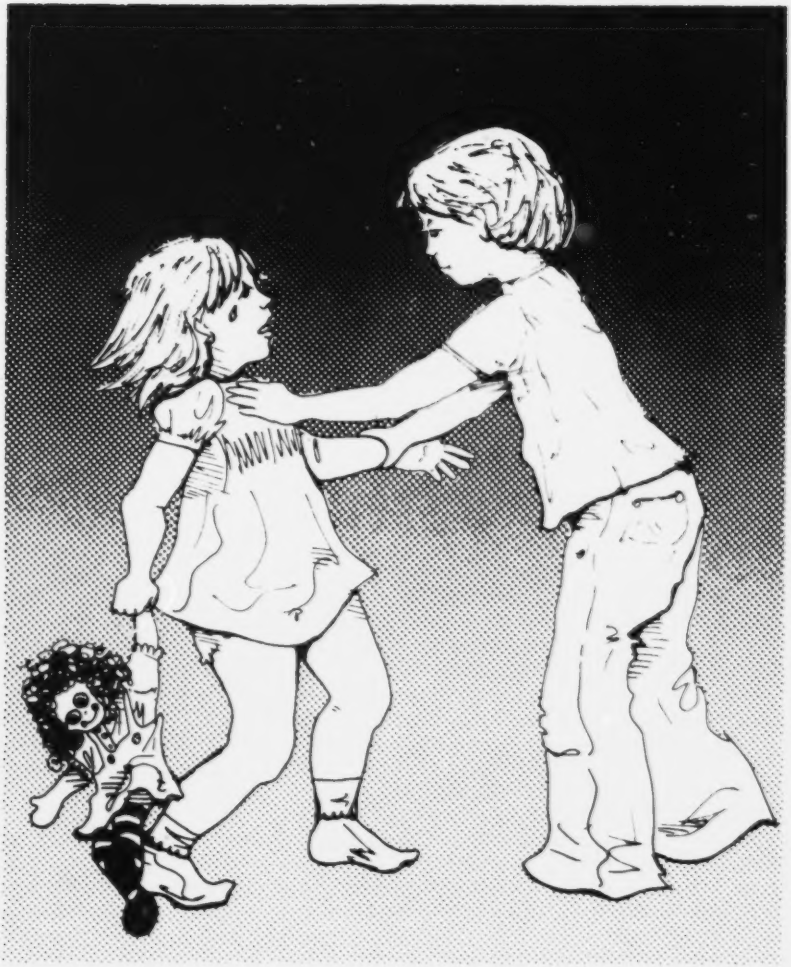
The Situation

Mark cannot sit still. At school he frequently does not complete his assignments, is often running around the classroom and disrupting other students with his incessant talking and clowning around. Mark acts impulsively—he often leaves the room without the teacher's permission. His impatience and frequent temper tantrums make it difficult for him to keep friends. Although he has average intelligence, Mark has trouble with his reading and writing, often reversing letters (b = p) and words (cat = tac).



At home, Mark has similar problems. He constantly fights with his younger sister, rides his bicycle recklessly, has difficulty catching a ball, and has trouble sitting through a television program. Because Mark has experienced few successes—academically as well as socially—he has begun to develop a very poor opinion of himself.



Identifying the Problem

Mark may be suffering from the hyperkinetic behavior syndrome,* previously called "minimal brain dysfunction" and commonly referred to as "hyperactivity" or "hyperkinesis." Although no one knows exactly how many children suffer from this childhood disorder, an educated guess based on research findings indicates that approximately 3 to 5 percent of all school age children are affected, most of them male.

Although actual *diagnosis of the hyperkinetic behavior syndrome is not simple,* hyperkinetic children typically have several characteristics in common; hyperactivity (overactivity) is just one of the symptoms and may or may not be present. The children tend to behave inappropriately in many situations. They appear unable to control their actions and seem to have much difficulty in *learning* self-control. They usually have short attention spans, are easily distracted or frustrated. Their behavior is often described as fidgity, restless, impulsive, and quarrelsome. They may have emotional problems and specific learning difficulties. While some children who are mentally retarded (have an IQ of less than 80) or who have major organic disability, such as cerebral palsy, may display similar behavior, these children do not fall within the diagnostic category of hyperkinesis.

Because diagnosing hyperkinesis is complex, getting opinions from one or more specialists is frequently desirable. Diagnostic evaluations should include a thorough examination by the child's pediatrician and, in some cases, consultation with a child psychologist, psychiatrist, or neurologist. Careful reports collected from parents, teachers, and school counselors are also helpful in properly identifying the hyperkinetic child.

What Causes Hyperkinesis?

The exact origin of the hyperkinetic behavior syndrome is unknown—no single cause has been established. The disorder has been ascribed to genetic, biological, physiological, social, and environmental factors.

Although there are many theories about the causes, hard evidence is scarce. For example, there is little evidence to support the theory of brain damage as a major cause. Since research has shown that the parents of some hyperkinetic children were themselves hyperkinetic, it may be that certain children inherit a predisposition for hyperkinesis. Other possible causes cited by various investigators include food additives, lead poisoning, vitamin deficiencies, and complications of pregnancy, including premature birth. Other investigators

*Also known as Attention Deficit Disorder, with or without Hyperactivity, according to the Diagnostic and Statistical Manual III (DSM III) of the American Psychiatric Association

attribute hyperkinetic behavior to parent-child relationships or to classroom teaching techniques. Most would agree that the disorder develops from a combination and interplay of genetic, environmental, neurological, and biochemical factors.

Current knowledge about the causes of the hyperkinetic behavior syndrome emphasizes the need for very thorough diagnostic evaluations before any treatment is undertaken. A child with behavior problems may not be hyperkinetic; instead he may be suffering from poor eyesight or hearing, allergies, improper nutrition, a chaotic home environment, physical disease, or emotional disorders. Much of the disagreement about the causes, prevalence, and treatment of the hyperkinetic behavior syndrome occurs because many children are assigned the diagnostic label without proper diagnostic evaluations.

How Is Hyperkinesis Treated?

There is really no "cure" for hyperkinesis. While research continues to seek an understanding of the underlying causes, treatments have been developed to provide relief of the symptoms. Management of the condition may involve a variety of methods.

- Medication: If a child has been diagnosed as hyperkinetic, his doctor may prescribe a "psychoactive" drug (a drug which acts primarily to affect mood, thinking processes, and behavior). The most effective medications, to date, are the stimulants. Administered properly, these drugs produce favorable therapeutic results in 70 to 80 percent of children with hyperkinesis. It was previously believed that the stimulants had a "paradoxical" effect in children, i.e., the drugs stimulate adults and calm children. Recent research has shown that, given equivalent dosages, normal adults and hyperactive children respond in much the same way; both exhibit improved attention spans and task performance. With medication, the child, no longer driven by his impulses, is more able to control his behavior. As a result, he frequently gets along better with his peers and, therefore, increases his self-esteem. In school his attention and concentration are better. Teachers frequently report that learning performance improves. The effects of medication also make the child more accessible to other forms of treatment such as special education procedures and counseling.

While stimulants are generally safe, their main side effects—insomnia, appetite loss and, in some cases, irritability, stomachaches or headaches—can be controlled by reducing the dosage and changing the time of day the drug is given.

A few fears have been expressed about the long-term use of medication in children. Some parents fear drug taking by their children will lead to dependency or drug abuse in adolescence or adulthood; others fear the drugs may be toxic. While these fears are understandable, the findings of most long-term research studies do not

support them. Of course, any type of medication must be used with caution, and children who are taking medications prescribed by a physician should be closely supervised and taught proper respect for the potency of drugs.

Fears that stimulant medication would cause significant growth suppression have not been borne out, and research findings indicate that small decrements in rate of growth are made up within two years after cessation of drug therapy. It is prudent for the physician to monitor the height and weight of the child at fairly regular intervals (i.e., about twice a year). The physician should also observe the child during "drug-free" periods such as summer vacation. During this time, the physician can reevaluate the child's need to continue medication or determine if dosages should be adjusted.

Stimulants are the physician's first choice of drugs when medicating a child with the hyperkinetic behavior syndrome. If a child does not show improved behavior after a week or two or if side effects, such as insomnia, persist, other types of medication are sometimes prescribed instead of, or concurrently with, stimulants. These include "major" tranquilizers, "minor" tranquilizers, antidepressants or antihistamines. Little systematic research has been done with the minor tranquilizers or the antihistamines, and, to date, the usefulness of these drugs is questionable. The major tranquilizers and antidepressants have been shown to be somewhat helpful, particularly for reducing hyperactive behavior, but not as effective as stimulants. Furthermore, the side effects of the major tranquilizers and antidepressants may be more severe than those of stimulants. Also, high dosages tend to reduce a child's ability to learn tasks which require sustained attention and, therefore, should be prescribed and monitored with great care.

• Diet: A still controversial therapy for hyperkinesis includes a special diet advocated originally in 1973 by the late allergist and pediatrician Ben Feingold, M.D., formerly with the Kaiser-Permanente Medical Center of San Francisco. This diet has strong appeal to parents who are unhappy about the use of medication for hyperkinesis. It excludes foods and medicines containing artificial flavorings and colorings, an ingredient called salicylate (a type of salt), and the preservatives BHA (butylated hydroxyanisole), BHT (butylated hydroxytoluene), and TBHQ (monotertiary butyhydroxylquinone) from the child's diet. Examples of foods eliminated from the child's diet are ice cream, bakery goods, luncheon meats, tea, powdered drink mixes, and other soft drinks. Some fruits and vegatables which are forbidden because they contain salicylates are blackberries, grapes, raisins, currants, peaches, strawberries, tomatoes, and cucumbers. Artificially flavored and colored medicines and vitamins are also excluded, as is common aspirin. While Dr. Feingold reported that, from his clinical experiences, some 30 to 50 percent of hyperkinetic children show improvement with

this diet, it is important to realize that the usefulness of the diet (or of more recently modified "defined diets" which are less stringent) for treating hyperkinesis has not been proven. Parents are encouraged to consult with their child's physician before the child undertakes such a diet, particularly since it may reduce the intake of certain important vitamins.

• Psychological interventions: Some parents have found it useful to combine drug treatment for the child with a program such as family counseling or behavior modification. While individual psychotherapy is generally of little benefit to the child, therapy for both the child and his parents can be helpful. By counseling, the therapist may help the parents to understand and deal more effectively with their child's problem.

Also, with the help and guidance of a competent therapist, parents can try one of many behavior modification techniques in learning to work better with their hyperkinetic child. Behavior modification typically involves rewarding desirable behavior and ignoring undesirable ones. A few examples follow:

Tommy's parents have set up a system of "token" rewards to assist him in controlling his behavior. Tommy, when he acts appropriately—by sitting quietly at the dinner table, for example—is rewarded with a token (coin). Tommy works to accumulate these tokens, which are later exchanged for a desired item and activity such as a special dessert or a trip to a favorite sporting event.

Bobby's parents have found a way to deal with his sloppiness, particularly his messy, unkept room. Mom, Dad, and Bobby have established a "contract" (usually a written agreement). All have agreed that if Bobby keeps his room neat for 1 week he will be given the special privilege of staying up later to watch a well-liked television program. But if Bobby does not clean up his room as he agreed to do, he is made to "overcorrect" his behavior. That is, he not only cleans up his own room, but also helps his sister and brother straighten up theirs.

Karen's parents use several techniques to help her control her behavior. First of all, they make sure they always praise her good behavior, especially after she has been punished for being bad and later acts appropriately. They also have used "modeling" techniques whereby they encourage her to imitate the good behavior of her friends and her favorite characters on television and in books.

• Some other ways to help: Because of his behavior, a hyperactive child may be in constant trouble both at home and in school. He may be described as a "bad boy." This label, in turn, leads him to develop a poor self-image. Parents can help a child feel better about himself if they learn effective ways of dealing with his behavior. For example, parents can help a child experience success by assisting

him in the completion of a small project such as a puzzle. They can help the child learn to control his impulsiveness by closely supervising his activities. Setting limits and making and enforcing rules can assist the child in gaining self-control. Overactive behavior may be channeled into sports activities such as wrestling and swimming. To cope with the child's short attention span and inability to complete tasks, they may divide his work into small units and praise him as he finishes each part of the task. Parents can also assist by sharing the child's interests and by helping him with his schoolwork.

Dr. Domeena Renshaw, in *The Hyperactive Child,* offers 18 suggestions to people who deal with hyperactive children: Be consistent in rules and discipline; speak quietly and slowly; keep your emotions "cool"; brace for expected turmoil; avoid a ceaselessly negative approach such as "Don't" or "Stop"; separate disliked behavior from the child (i.e., say: "This is bad behavior," not "You are a bad child."); have a clear routine for the child; demonstrate new or difficult tasks; try a separate room or part of a room which is the child's own special area; let the child perform one task at a time; give the child responsibility, become familiar with his pre-explosive warning signals; restrict playmates to one or, at the most, two at a time; do not pity, tease, be frightened by, or overindulge the child; know the name and dose of his medicines; openly discuss with the physician any fears you may have about the use of medications; lock up all medications; always supervise the taking of medication; share your successful techniques with the child's teacher.

• School: In addition to some of the previously mentioned techniques, helping the hyperkinetic child at school sometimes involves special education and tutoring. Because learning problems may indicate a hyperkinetic child, it is important that parents, teachers, doctors, and school counselors consult about special education opportunities available within the child's school system.

What Does the Future Hold for the Hyperkinetic Child?

There are differing opinions about what the future holds for the hyperkinetic child. The comprehensive, long-term studies needed to forecast the child's future adjustment are still underway, and much more needs to be learned before predictions can be made with any accuracy.

Some early studies have shown that, while overactivity tends to diminish in adolescence, the hyperkinetic adolescent may still be noticeably more restless, impulsive, distractible, and emotionally unstable than his peers. Underachievement, difficulties in focusing attention, and poor self-esteem may remain major problems even into adulthood, increasing vulnerability to delinquency, alcoholism, and mental illness.

Some clinicians believe that the future of the hyperkinetic child may be determined by whether or not the child receives *early* treatment. They reason that treatment which permits the child to exercise improved self-control will strengthen the child's self-image and reduce the risk of future problems. However, some clinicians believe treatment at any age is useful, and investigation into the effectiveness of treating adolescents and adults is now taking place.

On the other hand, there is some evidence that the flexibility and independence often found in adult life may be more compatible for the hyperkinetic individual than the restricted world of childhood. In some cases, hyperkinetic behaviors, which cause problems during youth, become assets in later life. Followup research has shown that a number of adults who were hyperactive as children are lively, energetic extroverts who function very successfully in jobs that allow flexibility and individual freedom and which require endless energy, an outgoing manner, and spontaneity.

Where Can One Go for Additional Assistance?

Organizations that can help in locating services for a child with special problems include the National Information Center for Handicapped Children and Youth, P.O. Box 1492, Washington, D.C. 20013, and the Association for Children and Adults With Learning Disabilities, 4156 Library Road, Pittsburgh, Pennsylvania 15234.

Other diagnostic sources are staff at outpatients' clinics of children's hospitals, university medical schools, and local community mental health clinics.

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13

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